CALIFORNIA MENTAL HEALTH PLANNING COUNCIL
MEETING HIGHLIGHTS
OCTOBER 20 AND 21, 2005
EMBASSY SUITES, BURLINGAME

Planning Council Members Present

Beverly Abbott
Michael Borunda
Doreen Cease
George Fry
Joan Hirose
Susan Mandel, PhD
Susan Nisenbaum
Daphne Shaw
Stephanie Thal, MFT
Barbara Yates, MD
Renee Becker
Jim Broderick, PhD
Adrienne Cedro Hament
Mike Greenlaw
Celeste Hunter
Dale Mueller, EdD, RN
Brandon Nunes
Joe Shimizu
Edward Walker
Jim Bellotti
Jorin Bukosky
Lana Fraser
Karen Hart
Carmen Lee
Jonathan Nibbio
Bettye Randle
Walter Shwe
Alice Washington

Staff Present

Ann Arneill-Py, PhD
Beverly Whitcomb
Brian Keefer
Cindy Walker
Connie Lira
Tracy Thompson
Nancy Stoltz
Jennifer Hays

Thursday, October 20, 2005

Ed Walker, Chairperson, noting that a quorum was present, convened the meeting at 1:05 p.m.

Presentation by the Mental Health Services Oversight and Accountability Commission

Darrell Steinberg, Chair of the Mental Health Services Oversight and Accountability Commission (MHSOAC), gave the following report on the Mental Health Services Act (MHSA):

- Proposition 63 passed in 2001 with 54 percent of the vote and much of the credit goes to the people who have persevered in mental health field for many years. Proposition 63 brought this issue out of the shadows politically and the mantra in the campaign was that, "everybody knows somebody."
- The system must now bring the same effort to implementation with the focus on outreach to the diverse communities of California to help people whether it's for their mental illness, substance abuse problem, housing, employment, etc. The system needs to show a demonstrable impact on the homeless problem in California, to keep children out of residential care, and to launch a campaign to fight stigma.

- The MHSOAC does not want to duplicate or replicate the work of the California Mental Health Planning Council (CMHPC) or the Department of Mental Health (DMH) but that the system stays singularly focused on big impacts.
- On 10/26/05, the MHSOAC will hold a major public hearing on housing and homelessness in Los Angeles. Stable housing is a critical factor in helping people.

Richard Van Horn, Principal Consultant, discussed community services and supports and how the MHSOAC is working to develop guidelines on transformation.

- The MHSOAC wants to ensure that it is honoring and collaborating with the CMHPC on the workforce development plan. Within the first four years of the MHSA, $350 million will be dedicated to workforce development.
- The first area of focus and the real transformation for the MHSOAC will be the Community Services and Supports (CSS) plans. The MHSOAC is looking at four basic indicator areas for reviewing the plans:
    1. Wellness, recovery, resilience
    2. A single fixed point of responsibility
    3. Processes and criteria for accessing Full Service Partnerships
    4. System development proposals
- The MHSOAC is building a matrix as the first few plans are being reviewed to test the reality of the above indicators.
- The second area of focus is on collaboration with other care partners in planning and how that collaboration will increase cultural competency. Community participation should be expanded to include non-traditional stakeholders, such as business, labor, and civic organizations.
- The third area of focus is education, training, and workforce development.
- The fourth area is consumer and family involvement, and how to increase ethnic and cultural diversity among consumer and family member participants.
- The focus in year one is to establish baselines as different counties are starting from different places. The MHSOAC wants to link evaluation and outcomes to baseline data and to determine a method for reviewing particular challenges of small counties. The MHSOAC will also focus on its general implementation oversight activities.

As a source of information for the MHSOAC, the following CMHPC members gave a brief presentation:

- Jonathan Nibbio provided information on the goals in the President's New Freedom Commission on Mental Health and how they relate to the California Mental Health Master Plan.
- Alice Washington discussed the use of performance outcome data.
- Adrienne Cedro-Hament discussed the CMHPC's Proposal for an Anti-Stigma Campaign focused toward older adults.

- Susan Mandel provided information on the Human Resources Committee's workforce development projects. Mandel stated that Lana Fraser has agreed to be the CMHPC's Human Resources Committee liaison to the MHSOAC's Workforce Development Task Force. A recommendation was made that the State use the education and training dollars wisely by increasing stipend programs and including mental health in loan forgiveness programs.

Comments/Questions and Answers

- Steinberg stated that Saul Feldman and Patrick Henning are Co-Chairs of the Workforce Development Task Force with the MHSOAC to begin the collaboration and encouraged the CMHPC to work with them on workforce issues.
- The State needs to look at the reality of the uninsured, which is seriously impacting the system.
- A concern was expressed about the impact of regionalization on services that will not be provided in the communities of the people that need those services. Do not ask families to go to the next county to get services for their children.
- Question: Will the anti-stigma campaign be done on a statewide basis? Answer: Maybe not in all 58 different counties but possibly on a regional basis. The Prevention and Early Intervention Task Force is focusing on an anti-sigma campaign, which is broader based. Mary Hayashi and Darlene Prettyman serve on this task force. The CMHPC and the task force could pool its resources on this campaign.
- Question: Is the DMH going to have the final word on these plans and how does the MHSOAC look at them and how is that going to work so we keep the energy going and we don't get it demoralized? Answer: The DMH has the final authority over the approval of the county CSS plans.

<u>Update on Implementation of the Mental Health Services Act</u>

Carol Hood, Deputy Director, Systems of Care, Department of Mental Health, reported on the status of implementation, policy clarifications, and future development of the MHSA.

Comments/Questions and Answers:

- Important to have effective training and retraining. The definition of recovery is not consistent. The *California Mental Health Master Plan* has a definition of recovery. People may be distorting definitions of recovery that may cause conflict or harm to clients who are part of the recovery process. When the DMH teams are reading the CSS plans everyone needs to be on the same page regarding the definition of recovery.
- The Human Resources Committee believes that a connection needs to exist between capital technology and the education and training plan because the need to use distance learning to move people along in the pipeline continuum is critical.
- Suggest including clergy in the stakeholder planning process, especially for the Asian community, as it is the entry point for many people.
- Is DMH looking at transforming the Medicaid reimbursement system? Answer: The DMH needs to look at every Medicaid requirement to determine if it is consistent with the MHSA.

This issue is included in the work plan; however, the DMH will not be addressing this issue until 2006 or 2007.

- Question: Will the DMH be issuing a ruling about whether short-term acute inpatient care will be covered under the MHSA? Answer: DMH will issue a ruling in early November.

Approval of the Minutes of the October 2005 Meeting

Minutes of the July 2005 Planning Council meeting were approved as submitted.

Approval of the Executive Committee Report

The Planning Council approved the Executive Committee report as presented. Please refer to the minutes of the Executive Committee for further details.

Ed Walker adjourned the meeting at 4:50 p.m.

Friday, October 21, 2005

Ed Walker, Chairperson, noting that a quorum was present, convened the meeting at 8:35 a.m.

Perspectives on the MHSA Planning Process

Robert Paul Cabaj, MD, Director of San Francisco Community Behavioral Health Services, Michael Medema of the San Francisco County Mental Health Board, Wayne Clark, PhD, Director of Monterey County Mental Health, and Alma McHoney, Chair, Monterey County Mental Health Commission provided the following perspectives and experiences during the local MHSA planning process in their counties. Dr. Cabaj, San Francisco County Community Behavioral Health Services, provided the following perspective:

- Putting the concepts in the MHSA into operation has really been the challenge. Part of the problem initially was waiting for instructions from the DMH on how to apply for CSS money.
- San Francisco formed its own stakeholder groups in early October prior to the DMH sending out guidelines.
- The Mayor of San Francisco created a 42-member task force that met every three weeks interspersed with subcommittee meetings. Eleven categories were created that partly followed age groups but also included specific conditions that are concerns in San Francisco, such as housing, homelessness, vocational rehabilitation, etc. An executive committee was formed to gather and review all the materials from the subcommittees to distill into a plan that the larger task force could grapple with. All the task force meetings were held in various parts of San Francisco.
- San Francisco tried to get the plan submitted by October 1 because the DMH would take about three months to review the plan but realized that the planning process could not be rushed and wanted to ensure the process was inclusive.
- Approval was needed by the San Francisco Health Commission, the Board of Supervisors, and the San Francisco County Mental Health Board. Several Board members spoke for their constituencies and brought forth issues they felt needed to be included in the plan, such as the issue of escalating violence in the county.

- The CSS plan totaled 700 pages when it was completed. The document is very technical; therefore, an 11-page summary was written and that was also condensed to two or three pages to make it easier for the Board of Supervisors to read.

Michael Medema gave the San Francisco County Mental Health Board's (MHB) perspective on the local planning process:

- One of the issues was how to keep the task force at 42 members to address all the issues. The MHB held seven, three-hour community meetings in various neighborhoods with two hours of those devoted to public testimony. The process included 66 subcommittee meetings, 120 peer-to-peer interviews, five focus groups, and the review of 80 position papers submitted from various organizations.
- The biggest issue at this point in the process has been the lack of education about the MHSA.
- This process has strengthened the relationship between the MHB and the San Francisco County Community Behavioral Health Services (Department) in ways that may not have existed before the MHSA.
- The MHB negotiated with the Department to run the public meetings. The Mental Health Association worked with the consumers to ease their concerns about speaking in front of the task force in a room of 200 people. Getting family members and consumers to meetings was a difficult task, which was partly due to meetings being held in the middle of the day. Consumers and family members showed up in droves at the larger task force meetings. The most raw and emotional testimony came from consumers and family members.

Wayne Clark, Monterey County Mental Health, reported on the perspectives of Monterey's MHSA planning process:

- Monterey County urged the use of continuous quality improvement and not to repeat the same bureaucratic process experienced with the CSS plans.
- The communities did not understand the meaning of full service partnerships, system development, or outreach and engagement.
- The Board of Supervisors approved the plan, which is 216 pages. Monterey County also created summaries as the plan was unreadable in its original form. The county went to the community and used the community's input and gap analysis to then generate themes and issues that became part of the plan. Monterey had 1,700 participants in 78 different stakeholder meetings. That process generated five themes, which included: 1) timely access to mental health services including geographically disparate locations; 2) wellness focus of recovery and resiliency; 3) integrated care, which includes substance abuse and mental health and also primary health care and mental health using evidence based practices; 4) cultural competence; and 5) supportive housing.
- Another theme from community members was the need for additional law enforcement programs. Law enforcement was very active in the process.
- One difficult aspect was that the community does not see the difference between prevention and early intervention and outreach and engagement. Those are definitions the State has

imposed on the counties that have to be included in the plan. Putting the plan together to meet the requirements of the State and then meet the needs and gaps was challenging.

- Monterey County held five public hearings that were held in all five Board of Supervisor districts. Three of the five supervisors attended those meetings.
- Mental Health Court costs became an issue. Monterey County received feedback from judges, clerks, district attorneys, and public defenders on the need to include court costs; however, the DMH indicated they were not allowable in the MHSA. Monterey County met with the Chief Administrative Officer and several of the above officials to discuss the possibility of a negotiated settlement. Monterey County asked what the DMH would do if the county included mental health court costs in its plan. The DMH replied that it would disallow those costs but that Monterey could spend that money for something else so the county agreed to submit the plan with the court costs and let the DMH take the action it needed to take.

Alma McHoney, Monterey County Mental Health Board:

- The Monterey County MHB had issues with the planning process and initially voted not to support the plan as submitted. The MHB requested Monterey County to make some changes.
- The process was valuable and very empowering for consumers. The MHB had 78 meetings and talked to 1,800 people.
- A problem for the MHB was not understanding all of the information and the process.

Questions and Answers:

- Question: Did either county give financial incentives to consumers and family members to attend the public meetings? Answer: San Francisco County paid $20 per meeting and provided snacks. Monterey County gave gift cards so as not to affect SSI income rules.
- Question: What did San Francisco do to get consumers and family members involved? Answer: San Francisco County went to local NAMI meetings and held subcommittee meetings there. San Francisco County also worked with the Mental Health Association to provide outreach to consumers and family members, and meeting times were shifted to accommodate people. Monterey County went out to the community where local meetings were being held.
- Question: Will other departments, such as Housing and Community Development, try to access some of the MHSA funds? Answer: Possibly to leverage funds. San Francisco received instructions from the State that it can support social services that go along with housing but not to actually build buildings. The funds could be used to support interface for clients in the system.
- Question: If the DMH does not approve the mental health court costs in the Monterey County CSS Plan, what will the money be spent on? Answer: Monterey County indicated that it may use the money for a wellness center.
- Question: Have you included education in the planning process since many family members are concerned about education for children and youth? Answer: Monterey County reported that it has 17 school districts and met with the superintendent of schools and with parent

groups. San Francisco County has not given clear guidelines regarding education, and school districts did not play much of a role.

- Question: How did you address getting non-English participants to attend the public meetings? Answer: San Francisco County provided translation services and equipment in numerous communities. Monterey County provided interpreters.

Report from the Department of Mental Health

Michael Borunda, Assistant Deputy Director, Department of Mental Health, provided a report on the activities of the DMH.

- The Department received a slight increase in the SAMHSA Block Grant.
- Ann Arneill-Py, Mike Borunda, and Ed Walker are working on preparing for the Block Grant Defense that will take place in Portland, Oregon in early December. This year the Block Grant Defense will focus more on CMHPC activities than department activities.
- The DMH is anticipating that co-occurring disorders will be a big part of the MHSA in the CSS plans. Borunda has looked at two plans and one of them focuses on co-occurring specifically so this is an issue that the State is committed to. Dr. Mayberg and Kathy Jag have formed a Co-Occurring Joint Action Council and Borunda is on that Council to further the efforts of the State. It's a place to talk about policy and implement actions through funding that focus on co-occurring disorders.
- The DMH has conducted intensive technical assistance sessions with counties regarding the MHSA. The DMH piloted five counties with a technical assistance team to assist with questions from counties on developing their CSS plans. The amount of resources for those pilots could not be sustained by the DMH so it continued offering technical assistance sessions on an individual basis through conference calls..
- The DMH and the California Institute for Mental Health (CIMH) are conducting extensive regional trainings for counties on MHSA implementation strategies focusing on the programmatic aspects, such as full service partnerships, wraparound, and programs similar to AB 2034.
- The DMH is currently undergoing onsite accreditation survey by the Joint Commission on the Accreditation of Hospitals and Healthcare Organizations (JCAHO). In the future, all JCAHO accredited facilities will be surveyed on an unannounced basis.
- Coalinga State Hospital opened on September 6, 2005. Coalinga will house the sexually violent predators transferred from Atascadero on a flow basis as staff are hired and additional beds are added. Coalinga will also receive 50 patients later in the year from the Department of Corrections and Rehabilitation. Coalinga is the first new state hospital in California since Atascadero opened in 1954. When fully occupied, the hospital will house 1,500 individuals.
- Regarding possible contempt orders for the DMH, even with the recent opening of Coalinga State Hospital there continues to be a growing number of referrals to the hospitals from the courts. In order to accept as many referrals as possible the hospitals continue to over-bed above licensed capacity when allowed under the law. Napa State Hospital is statutorily limited to the number of forensic patients it can house, which is 980 and it is at that level

now. This has resulted in delays of admissions and waiting lists for state hospital services. Several courts have begun issuing orders to show cause to obtain expedited admissions of patients from their county jails with the threat of fining the Director of Mental Health and the hospital executive director. This has resulted in further admission delays in other counties as DMH addresses the orders to show cause. This problem will likely continue until sufficient beds come online at Coalinga and/or there is a significant reduction in forensic patient referrals to the hospital, which is unlikely based on court referral trends over the last few years.

- The DMH recently received a $1 million FEMA grant to assist victims of the Katrina disaster who are living or temporarily living in California. The money will be used to provide counseling and other support for victims of Katrina.
- Lastly, on the MHSA the DMH has made a stronger outreach to tribal organizations. DMH is privileged to announce that the director has approved a series of meetings with tribal representatives. DMH is having its second meeting on Monday and the goals are to establish a relationship to help understand and dialogue with tribal members about how to further serve a population that has been historically unserved or underserved in the past.

Question and Answers

- Question: How long is the waiting list for jail inmates to get a bed at a state hospital? Answer: Borunda can provide that information to Arneill-Py who will email the information to the CMHPC.

Public Comment

Connie Reitman, Executive Director, Inter-Tribal Council of California

- Reitman stated that the Inter-Tribal Council of California is an association of 47 tribes from throughout the State. Reitman learned about the MHSA in June or July and its implementation in the State of California. The Tribal Council surveyed tribes throughout the State and found that maybe one tribal group was involved in the MHSA stakeholder process. This gives rise to some concern because California is home to the largest population of Native Americans (109 tribes) in the United States. The Tribal Council addressed its concerns with the MHSOAC and the comments were well received. The MHSA includes language that the Tribal Council felt was really going to create some change in addressing accountability, outcomes, cultural proficiency, ethnic disparities, and unserved and underserved communities. The tribal communities felt that this was an opportunity to get its foot in the door but that did not happen. Historically, the relationship between tribal people and counties is not a very positive one. Tribal people are not well represented on the local boards or represented at the table at any level. The problem in addressing tribal issues is that very little data exists about the provision of services to this particular population and very little outreach has been conducted. Reitman expressed the importance of recruiting individuals who can work at the DMH and within the different agencies that provide expertise and recommendations for this population.

Andrea Hillerman, Consumer Advocate Liaison, Sacramento County

- Hillerman addressed creating a definition for recovery and the importance of asking consumers what their definition of recovery is. The Wellness Recovery Action Plan states that recovery is very individualized and the definition is constantly evolving.

Susan Gallagher, Mental Health Association, Sacramento, provided testimony, which is included as Attachment A.

Steve Leoni, Client and Advocate, San Francisco

- Leoni addressed the disparity between the idealistic and realistic approach to transforming the mental health system with limited MHSA dollars. Leoni views this opportunity as an opening wedge to transform the system. One of the things that wraparound in the children's arena and the AB 2034 program in the adult arena do very well is to divert people from going to state hospitals and IMDs. Much of a county's budget is tied up in those institutions. The term tertiary prevention is used in the early intervention and prevention component that deals with people who are already ill but the system is able to do outreach and have places for them to go in the community before they take the next step to the state hospital setting or if they do move to that level they do not stay very long and the net effect is to reduce the demand on the hospitals so they ultimately would not need as many beds. By reducing that demand for higher levels of service the money could be used for community services. The system should enable people to better deal with themselves, to have peer relations, and to have natural supports in the community so that as people stabilize they need fewer formal services while still maintaining the momentum of recovery.

Susan Bowen, Consumer and Consumer Advocate, San Mateo County

- Bowen stated that her experience participating in all the MHSA meetings in San Mateo County and other counties is that the money for employment opportunities for consumers and family members will not be used for county positions but mainly on a stipend basis or voucher basis. The counties seem to feel that consumers and family members should be grateful for any position offered to them. Bowen has a masters degree in special education and can read and speak Chinese fluently and would like to help the county Through the MHSA process the county has tokenized the consumers and family members; however, they have other specialties to offer. Bowen is here to work for the big cause. Please listen to consumers and family members.

Allison Mills, San Mateo County

- Mills reported on the local MHSA planning process, which was the largest undertaking the county has ever participated in and it touched the lives of at least 1,000 people with focus groups and public forums. Most important was the collaboration and relationships that were formed with people from Alcohol and Drugs, Criminal Justice, and Child Welfare. Most important were the relationships and collaboration of family members and consumers. They are truly the full service partners.

Janet King, Alameda County

- King expressed concern that although the sign-in sheets at the local MHSA planning meetings reflected attendance by Native Americans, their concerns and comments were not considered. The data shows that Native Americans are 107 percent overserved but that is not true. Native Americans are underserved but are not being engaged in the process. The data is incorrect and flawed. King is on the Cultural Competence Planning Committee in Alameda County and in reviewing proposals they do not include Native Americans. King is grateful that more steps are being taken to significantly engage Native American communities.

Linford Gale, Consumer, San Mateo County

- Gale has concerns about system transformation when the system does not really want to transform anything. Gale is referring to the requirements and the difficulty in being hired in a county or state position and the hoops one has to jump through, which is very discouraging for people of color. If one looks at the powerful consumer movement and these intelligent people working to better the system but they do not qualify for jobs and they can work circles around someone who just graduated from college with a degree this is not transformation. The system is giving lip service but transformation needs to start at the top and not at the bottom. If the system wants to include people of color and ethnicity groups then they need to be represented somewhere.

Nancy Stoltz, Consumer, Sacramento County

- Stoltz addressed the issue of hiring consumers and family members. The State Limited Examination Appointment Program (LEAP) program should be expanded to include more classifications for disabled people. Certain jobs exist under the LEAP that a person with a disability can apply for. Lana Fraser serves on a State Personnel Board (SPB) task force and will take that recommendation forward. Fraser stated that the Governor issued an Executive Order, which talks about making the State a model employer and issues about LEAP. The Employment Development Department added some entry level positions to the LEAP categories. Borunda indicated that the SPB and the Department of Personnel Administration (DPA) set the standards for classification and testing. This is a good suggestion to take back to state directors and work with SPB and DPA to spearhead a movement toward better hiring. Walker also suggested that the DMH and the CMHPC could work on this possibly with the CMHDA to engage the county personnel departments to address this issue. Walker suggested that the Human Resources Committee could address this issue.

Report from the California Mental Health Directors Association

Gale Bataille, Director, San Mateo County Mental Health, reported on the following CMHDA activities:

- Seventeen counties have posted their CSS plans. People can get direct links to all of the posted plans by going to the www.cimh.org website. Three plans have come into the State.
- San Mateo's plan will go to the Board of Supervisors on November 8th, 2005 followed by the Mental Health Board review.
- The CMHDA adopted principles on prevention and early intervention for the purpose of statewide dialogue. A few of the principles include: prevention and early intervention needs to align with the basic direction that has rolled out with the MHSA. Need to focus on mental illness or serious emotional disturbance becoming more debilitating for people and the need to identify and intervene early. Need to make sure prevention and early intervention efforts focus not only on the community, but on age-targeted strategies to be effective. The CMHDA strongly believes that whatever is done in that arena needs to continue to align with the transformative vision that is a part of the CSS, which needs to include recovery, resilience, and consumer and family member involvement. Ensure values that have been articulated very well remain values and guiding principles for prevention and

early intervention, including cultural competence. Staff will send the principles to the CMHPC members.

- The State needs to articulate a framework for prevention and early intervention so that counties understand what these services need to be evidenced based.
- The CMHDA is waiting for the DMH to get guidance from the DOF and the Governor on AB 3632. This is a serious concern for counties. CMHDA adopted principles.
- Medicare Part D is troubling to family members and consumers. The CMHDA has a Medicare workgroup that disseminates information out to all counties. Erin Riggs, CMHDA is the lead on Medicare Part D.

Questions and Answers

- Question: When will the AB 3632 dollars run out? Answer: The Governor approved funding for FY 2004/05 and FY 2005/06, although funding could run out sooner. Jim Bellotti, Department of Education (DOE), stated that it is dependent upon the amount of claims that counties submit to the State. Bellotti stated that three Special Education Local Plan Areas representatives have met with the DOE and the Legislative Analysts Office and proposed a pilot program to take over the AB 3632 program in three different counties of the State; however, the Legislature is not supportive of pilot studies.

Report from the California Association of Local Mental Health Boards and Commissions (CALMHBC)

Cary Martin, President, provided a report on the activities of the CALMHBC:

- Request that the CMHPC be more aware of veteran's issues. Twenty-five percent of veterans are from California and a large percent of the homeless population are ex-military.
- The MHBs need logistical support for local operations. The mental health boards are viewed as local troops with oversight of mental health services. Local mental health boards are doing yeomen's work in the MHSA process.
- The MHBs experience high membership turnover and need training on improving its relationship with local mental health departments and the community. The need exists for a continual process for training new board members. Successes are predicated on good practices and training. The training manual will be released in January.

The meeting was adjourned at 12:20 p.m.

Respectfully submitted,

Cindy Walker
Associate Mental Health Specialist